# Quality Improvement for Ethnically Diverse Populations "Place and Race Matter"

August 1, 2011

The Right To Care Initiative

University Best Practices

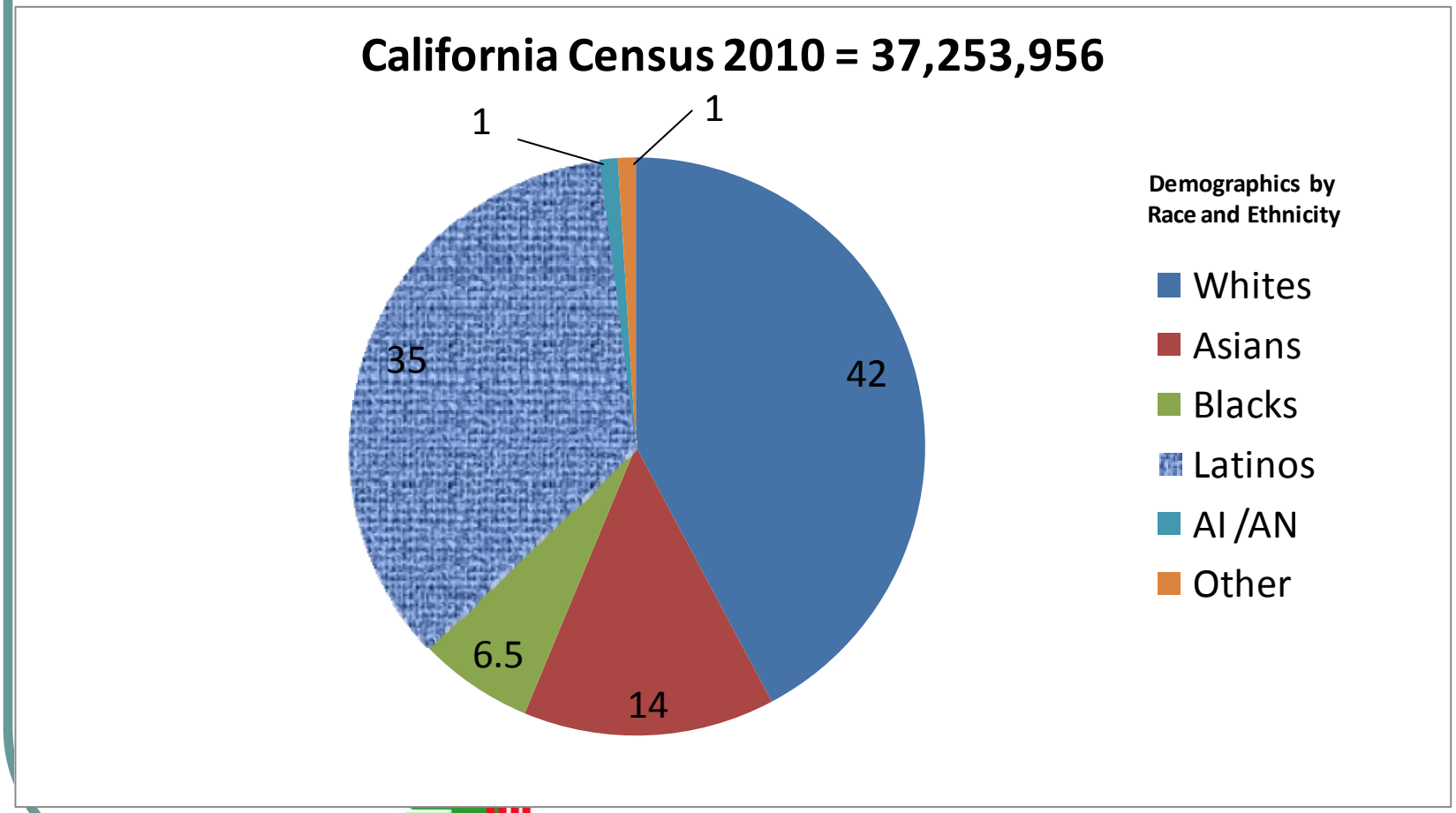
Rodney G. Hood, MD

President

MultiCultural IPA

MultiCultural Primary Care Medical Group, Inc.

# California with No Majority Population

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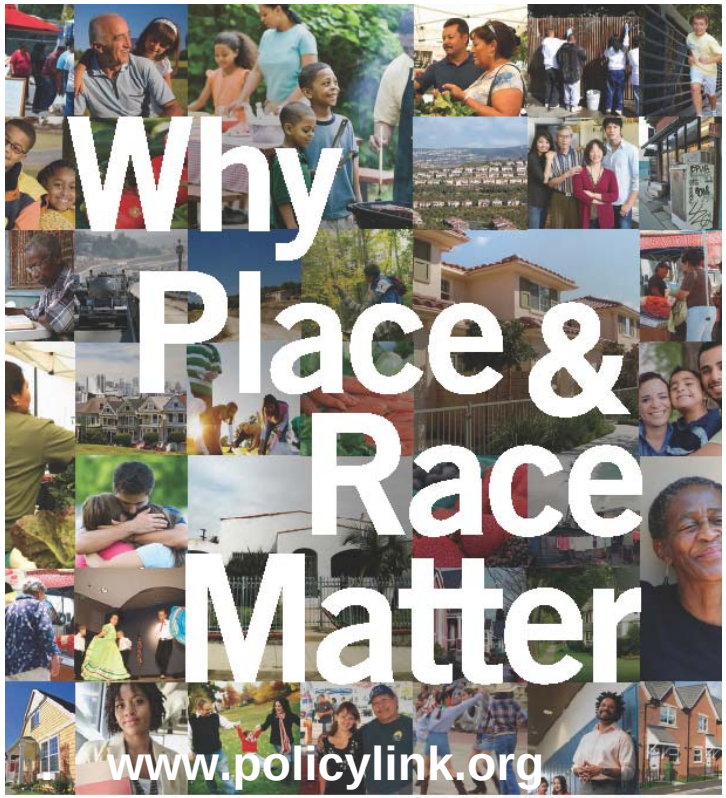
# Health Status and Outcomes




"PolicyLink and The California Endowment have long recognized that place and race matter. Despite the fanciful talk in the media about a "postracial" society following President Barack Obama's election, most neighborhoods are segregated along racial lines……. Our research and our conversations with people working in the field have reaffirmed our belief that place matters. By the same token, race matters—a lot. " - **2011**

**Robert K. Ross, MD**
*President and CEO*
*The California Endowment*

**Angela Glover Blackwell**
*Founder and CEO*
*PolicyLink*

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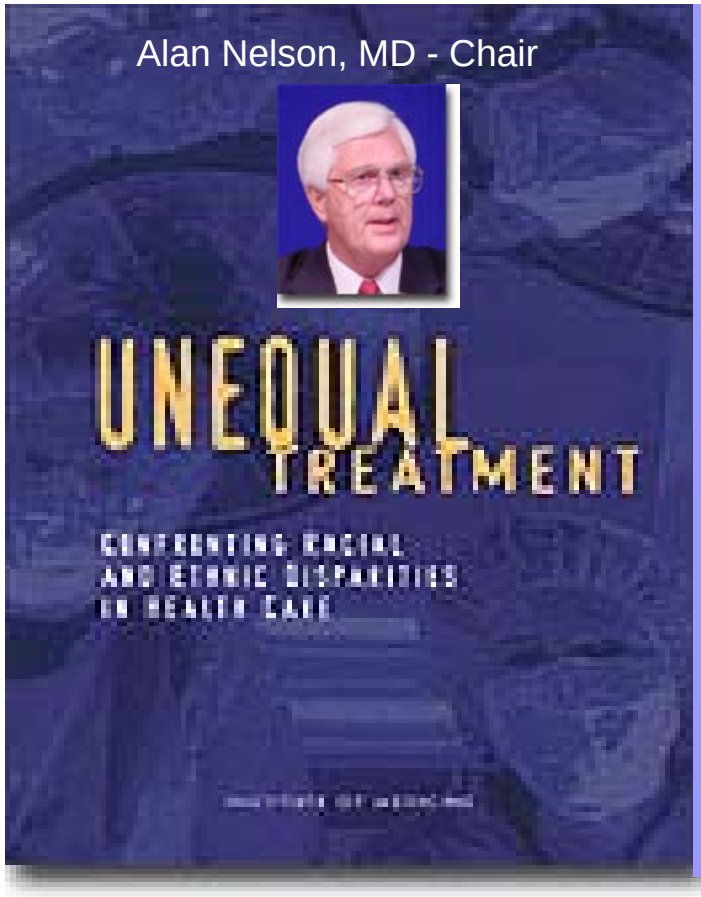
# IOM Study Confirms Persistent Racial and Ethnic Health Disparities in US - 2002




**Institute of Medicine study confirms the presence of racial and ethnic health disparities and the contribution of discrimination, bias, and stereotyping leading to inequities in health care.**

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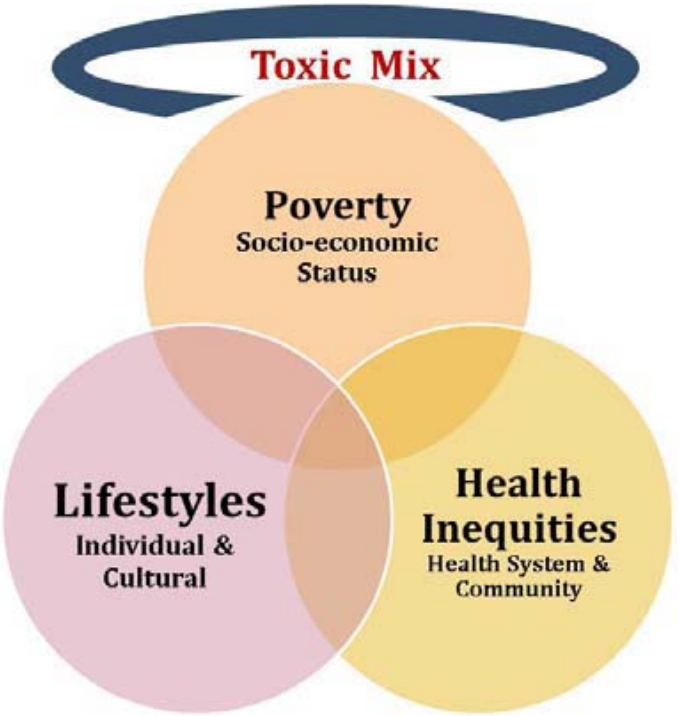
# Root Causes of Health Inequities and Disparities

**Causes from the 2011 CDC Health Disparities and Inequities Report**

- Physical Environment (place)
- Race and Ethnicity
- Biological and Genetic Considerations
- Individual Behaviors (Lifestyles)
- Access Barriers
- Socio-economic Conditions
- Social Support Networks

## Toxic Mix

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# Quality of Care and Access to Care Comparisons by Selected Racial Groups 2000 – 2001

## National Healthcare Disparities Report 2004 (AHRQ)

| | Blacks | Hispanics | AI/AN | Asians | Poor |
|---|---|---|---|---|---|
| % lower quality of care compared to whites | Approx. 66% | Approx. 50% | Approx 33% | Approx. 10% | Approx. 60% |
| % lower access to care than whites | Approx. 40% | Approx. 90% | Approx 50% | Approx. 33% | Approx. 80% |

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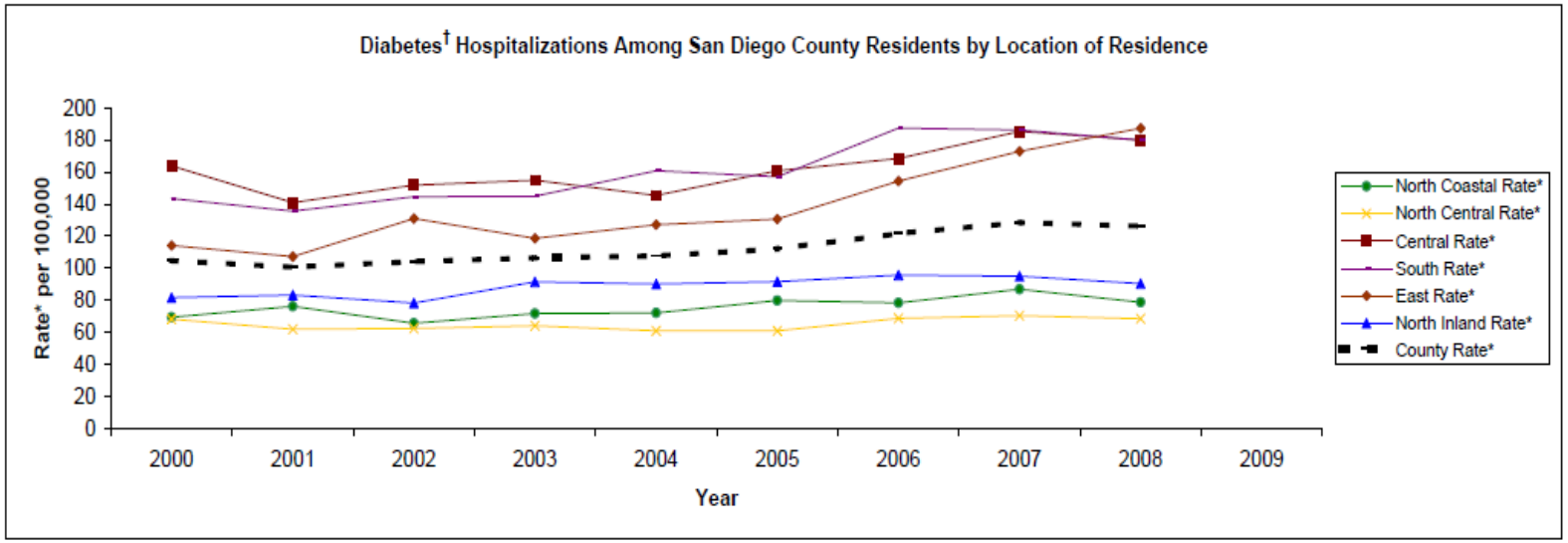
# Place Matters

| Category (per 100,000 people) | San Diego County | Central San Diego | Percent Difference |
|---|---|---|---|
| HIV/AIDS (Rate)* | 15 | 45.3 | +202% |
| Diabetes (Hospitalizations) | 111.8 | 196.9 | +76% |
| Asthma (Hospitalization) | 309.4 | 458.9 | +48% |
| Infant Mortality | 4.5 | 6 | +33% |
| Heart Disease (Deaths) | 162.8 | 205.5 | +26% |
| Prostate Cancer (Deaths) | 23.9 | 29.5 | +23% |
| Stroke | 225.9 | 274.1 | +21% |
| Health Insurance (Adults) | 83.8% | 75.4% | -10% |
| Health Insurance (Kids) | 85.4% | 75.4% | -12% |
| Breast Cancer | 28.2% | 28.2% | 0% |
| Cervical Cancer | 1.9% | 2.8% | +47% |

County of San Diego Health and Human Services Agency, Public Health Services. "Core Public Health Indicators: September 2004. "

* Compiled by Health and Human Services Agency, San Diego County HIV, STD, and Hepatitis Branch and Community Epidemiology Branch : April 2007

# San Diego County
# Diabetes Hospitalizations by Region




* Rates per 100,000 population.

† Diabetes hospitalization refers to (principal diagnosis) ICD-9 code 250

§ Rates not calculated for fewer than 5 events. Rates not calculated in cases where zip code is unknown.

Source: Hospital Discharge Data, (CA OSHPD), County of San Diego, Health & Human Services Agency, Epidemiology & Immunization Services Branch; SANDAG, Current Population Estimates, 4/24/2009.

Prepared by County of San Diego (CoSD), Health & Human Services Agency (HHSA), Community Health Statistics, 8/12/2010.

# Race Matters

| San Diego County Category (per 100,000 people) | White | Latino | African American |
|---|---|---|---|
| HIV/AIDS (Rate)* | 13.1 | 17.1 | **46.9** |
| Diabetes (Hospitalizations) | 88 | 213 | **283** |
| Asthma (Hospitalization) | 260 | 347 | **621** |
| Infant Mortality | 4.1 | 3.6 | **14.4** |
| Heart Disease (Deaths) | 167 | 141 | **266** |
| Prostate Cancer (Deaths) | 24.2 | 17.4 | **59.6** |
| Stroke | 209.9 | 273.6 | **337.4** |
| Health Insurance (Adults) | **90.6** | 62.5 | 89 |
| Health Insurance (Kids) | **93.1** | 72.4 | 96.3 |
| Breast Cancer | 30.4 | 20.4 | **36.6** |
| Cervical Cancer | 1.4 | **1.9** | - |



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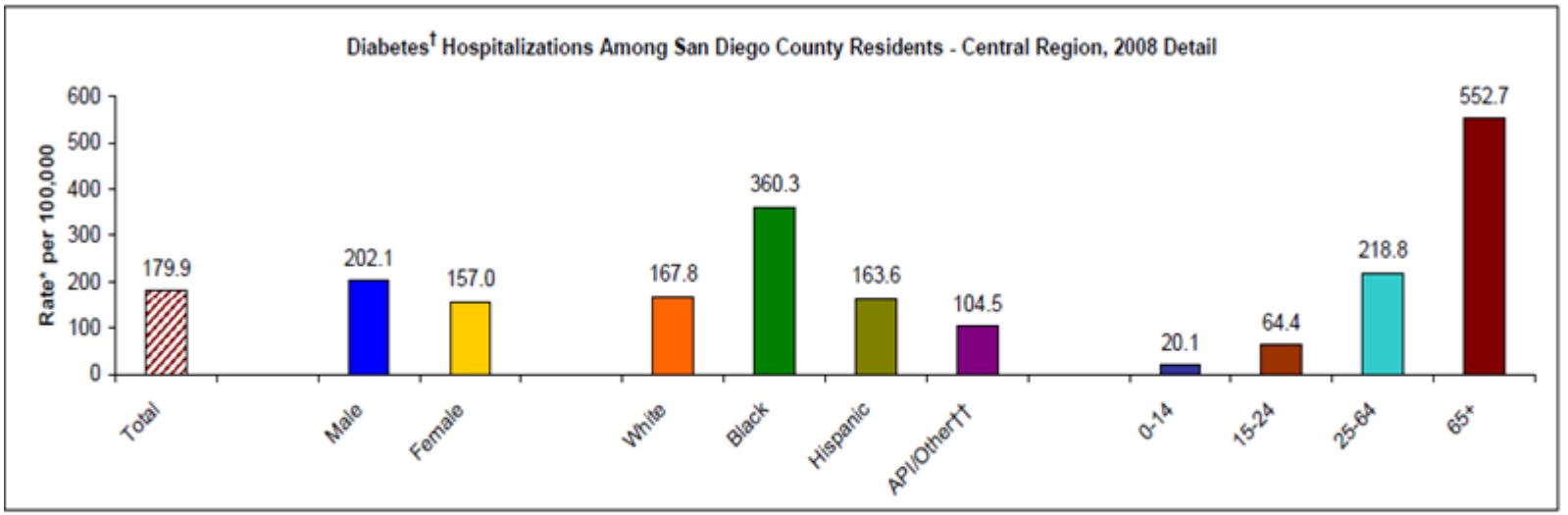
County of San Diego Health and Human Services Agency, Public Health Services. "Core Public Health Indicators. September 2004. "

* Compiled by Health and Human Services Agency, San Diego County: HIV, STD and Hepatitis Branch and Community Epidemiology Branch . April 2007

# San Diego County
# Diabetes Hospitalizations by Race and Ethnicity




* Rates per 100,000 population.

† Diabetes hospitalization refers to (principal diagnosis) ICD-9 code 250

†† API/Other includes Asian, Pacific Islanders, those reporting 2 or more race/ethnicities, other, or had missing information.

§ Rates not calculated for fewer than 5 events. Rates not calculated in cases where zip code is unknown.

Source: Hospital Discharge Data, (CA OSHPD), County of San Diego, Health & Human Services Agency, Epidemiology & Immunization Services Branch; SANDAG, Current Population Estimates, 4/24/2009.

Prepared by County of San Diego (CoSD), Health & Human Services Agency (HHSA), Community Health Statistics, 8/12/2010.

# San Diego County Demographics by Race, Ethnicity and Disease Burden

- Latinos, African Americans and Immigrant populations have high concentratuions in the Central and South regions of San Diego County.

- SD County Health Needs Assessment Report (2004):
  - *Populations with the highest disease burdens and greatest obstacles to access health care are found in the Central and South regions with African Americans suffering the highest disease burdens and Latinos the worst access.*

  - *Populations living in the Central and South regions of San Diego County have the highest hospitalization and death rates from diabetes, asthma, CHD and cancer.*

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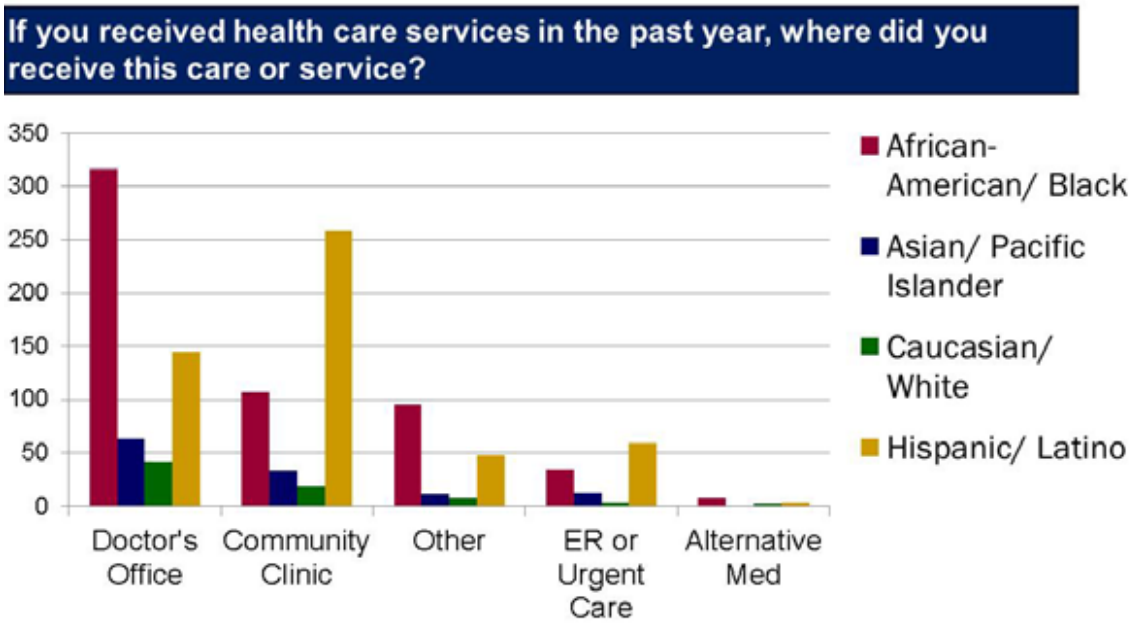
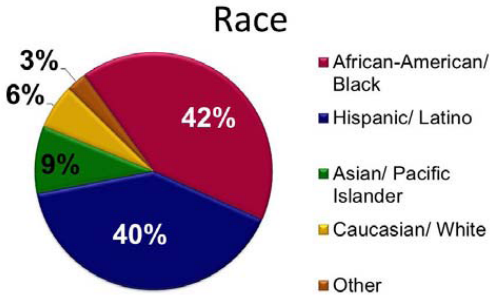
# Southeastern San Diego Community Preferences Place of Healthcare - 2010

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# Southeastern San Diego Community Economic and Insurance Demographics

- Nearly 65% of households earn less than $45,000 annually
- However over  50% of the population is covered by commercial or Medicare
- Approximately 22% of the population is covered by Medi-Cal
- Approximately 20% are uninsured

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# Quality Measures

Racial and Ethnic Quality Measure Disparities

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# Health Care Quality Indicator Disparities

August 2006 issue of the *American Journal of Preventive Medicine*

- In 2000 – 2001, the overall biennial breast screening rates for women 40yrs and older were:
  - 50.6 percent for non-Hispanic white women
  - 40.5 percent for black women
  - 34.7 percent for Asian-American women
  - 36.3 percent for Hispanic women, and
  - 12.5 percent for Native-American women.
- Therefore, 20% – 75% lower rates for minorities
- **In California, women with insurance have an overall breast screen rate at 64% but approximately 70% for whites but less for Asians (Filipino & Chinese), immigrants, non-English speaking and other minority women.**
- **Self-reported cancer screening for PAPS and mammography for African Americans and Latinos are near or equal to whites but when documented by medical records the actual screening rates are significantly less.**

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# Racial Differences in HbA1c Levels

- HbA1c levels were higher in Blacks than in Whites with normal glucose tolerance after adjustment for other variables (Ziemer DC, Ann Internal Med, 2010)

- Comparing Black and White diabetic patients persistent racial differences in HbA1c were found that were not totally explained by differences in medication adherence. (Alyce, SA, et al, Diabetes Care, May 2008- Harvard Medical School)

- Race Differences in Long-Term Diabetes Management in an HMO (Diabetes Care, Dec. 2005)

  Concluded: Race differences in diabetic outcomes over 4 – 8 years in a single HMO, Black patients had higher A1c values than Whites that persisted with time despite similar treatment and visits.

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# HbA1c Differences by Race and Ethnicity

Differences in A1c by race and ethnicity among patients with impaired glucose tolerance (IGT) in the Diabetes Prevention Program
(Diabetes Care, Vol 30, No 10, October 2007)

| | Whites | Latinos | Asian | Am Indians | Blacks |
|---|---|---|---|---|---|
| Unadjusted A1c | 5.80 | 5.89 | 5.96 | 5.96 | 6.19 |
| Adjusted A1c | 5.78 | 5.93 | 6.00 | 6.12 | 6.18 |

**Conclusion:** A1c levels are higher among U.S. racial and ethnic minority Groups with IGT after adjustment for factors likely to affect glycemia. A1c may not be valid for assessing and comparing glycemic control across racial and ethnic groups.

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# Percent Adults Achieving CV Risk Goal
# Kaiser Permanente Georgia (2010)

| | AA Women | AA Men | White Women | White Men |
|---|---|---|---|---|
| SBP <130 & DBP <80 | 53 | 54 | 58 | 63 |
| HDL > 50 mg/dl | 39 | 17 | 30 | 10 |
| LDL <100 mg/dl | 52 | 66 | 61 | 74 |
| HbA1c <7% | 39 | 42 | 49 | 50 |
| **BP <130/80 LDL < 100 HbA1c <7%** | 12 | 15 | 19 | 22 |

**Conclusion: African Americans were less likely than Whites to achieve goals for BP, LDL-C, or HbA1c and were only two-thirds as likely to achieve all three goals (13.6% vs 19.6%).**

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# History Multicultural IPA

- MCIPA was founded in 1993 and managed by UCSD Healthcare MSO
- In 2003 the IPA signed a management agreement with SynerMed MSO
- MCIPA contracts over 120 PCPs and 100 specialists located in San Diego County concentrated in the Central and South regions.
- Physicians are mostly in solo and small medical groups located in ethnically diverse neighborhoods.
- MCIPA has over 13,000 capitated lives with mostly commercial and senior enrollees (approx. 1600 MediCal)
- However, MCIPA physicians serve over 240,000 ethnically diverse patients with significant MediCal and healthy families populations.

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# California HMO Report Card 2005
# Medical Groups in San Diego County

- The California Integrated Health Association (IHA) P4P Initiative rated the Multicultural IPA quality performance fair to poor

- If QI measures and P4P are designed to improve medical quality in a cost efficient manner utilizing evidence-based medicine, then we ask?
  - Whose evidence?
  - Based upon what assumptions?
  - Quality improvement for who?
  - At what cost?

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# Early Experience with Pay-for-Performance in California

## Rosenthal, et al, JAMA, Oct. 2005 (Harvard School of Public Health)

- Finding:
  - For all 3 measures (cervical cancer screening, mammography and hemoglobin A1c), physician groups with baseline performance at or above the performance threshold for receipt of a bonus improved the least but garnered the largest share of the bonus payments ($3.4 million).
- Conclusion:
  - “Paying clinicians to reach a common, fixed performance target may produce little gain in quality for the money spent and will largely reward those with higher performance at baseline.”

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# Disproportionate Enrollment Minority Patients Can Result in Poor Quality Performance Doe to:

- Inadequate baseline reimbursements for population served
- Excessive administrative cost withholds
- Racial and ethnic quality indicator disparities
- Incomplete encounter data collections
- Unfair population quality measure comparisons
- Tiered physician networks and economic profiling
- De Facto racial, ethnic and SES discrimination
- Geographic physician shortages
- Potential worsening of health disparities

**Hood, R, Pay-for-Performance and Financial Health Disparities and the Impact on Healthcare Disparities, JNMA, August 2007**

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# Geographic Physician Shortages

- Many minority and underserved populations live in physician shortage areas.
- Providers serving in underserved communities commonly have heavy patient loads.
- Poor access results in longer waits during office visits.
- Patient survey criteria many times penalize providers for practicing in communities where other providers avoid working.

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# Physician Shortage Leads to High Patient Volumes

- San Diego County population is approximately 3 million with 8,700 physicians.
- Physician:population ratio in San Diego County is 1:350.
- Physician:population ratio for MCIPA service areas is approximately 1:1500.
- Therefore, MCIPA service areas have a physician shortage of 4 times fewer physicians than other parts of the county.

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# Incomplete and Inaccurate Encounter Data Collection Results in Lower Quality Indicator Scores

- Encounter data is utilized to measure a physician groups' level of compliance for quality improvement measures.
- Groups designated as self-reporting perform better P4P scores (large groups with integrated IT).
- Physicians not associated with integrated EHR capacity tend to have higher rates of incomplete encounter data submission.

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# Worsening Health Disparities

- P4P programs that do not fairly and equitably compensate for high-risk populations and utilize inaccurate evidence-based quality indicator comparisons will not enhance the elimination of health disparities but may actually worsen health disparities.

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# Quality Improvement Solutions to Address Health Disparities

A focus that is population specific

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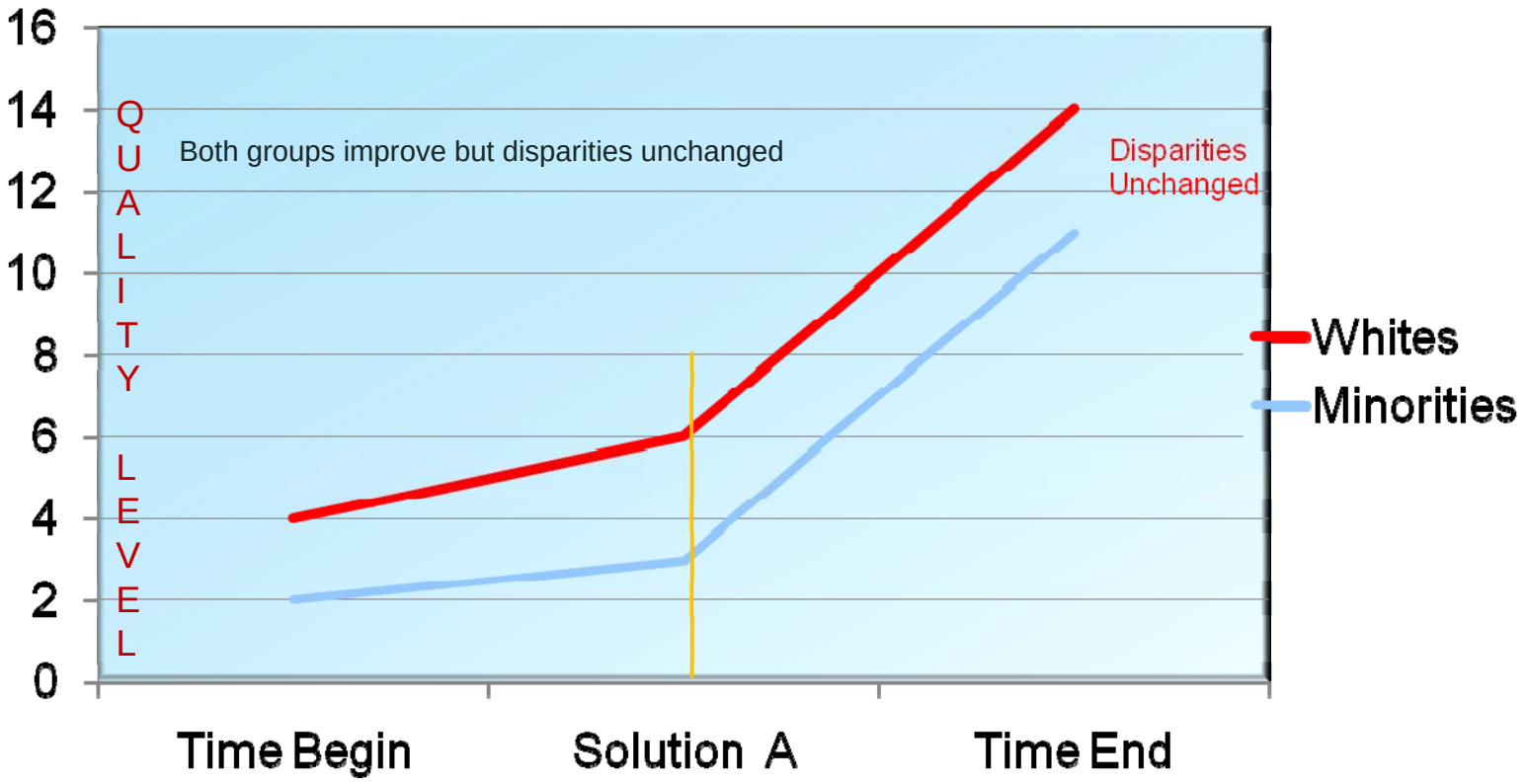
# Quality Improvement and Consequences of Chosen Solution to Eliminate Ethnic and Racial Disparities

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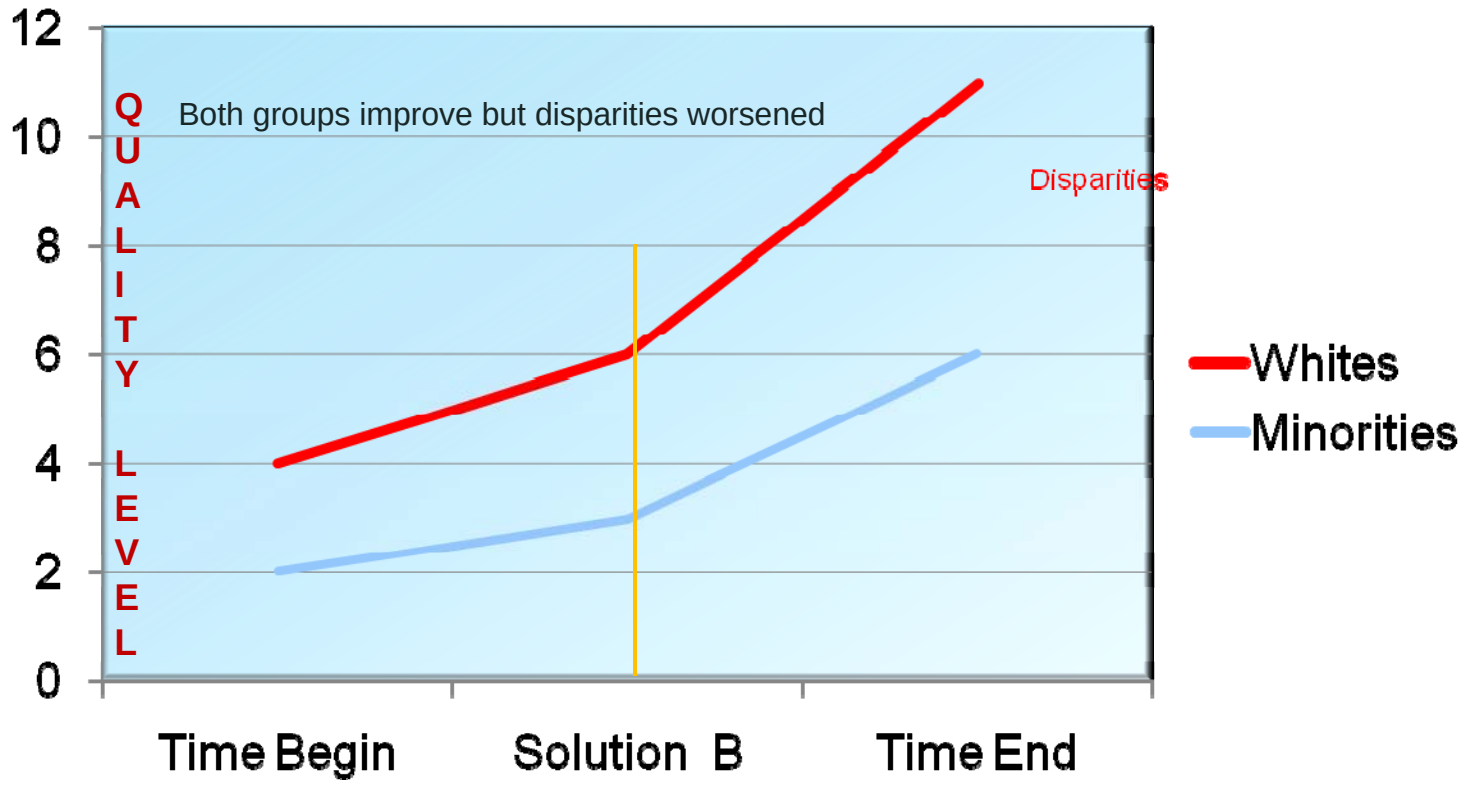
# Quality Improvement and Consequences of Chosen Solution to Eliminate Ethnic and Racial Disparities

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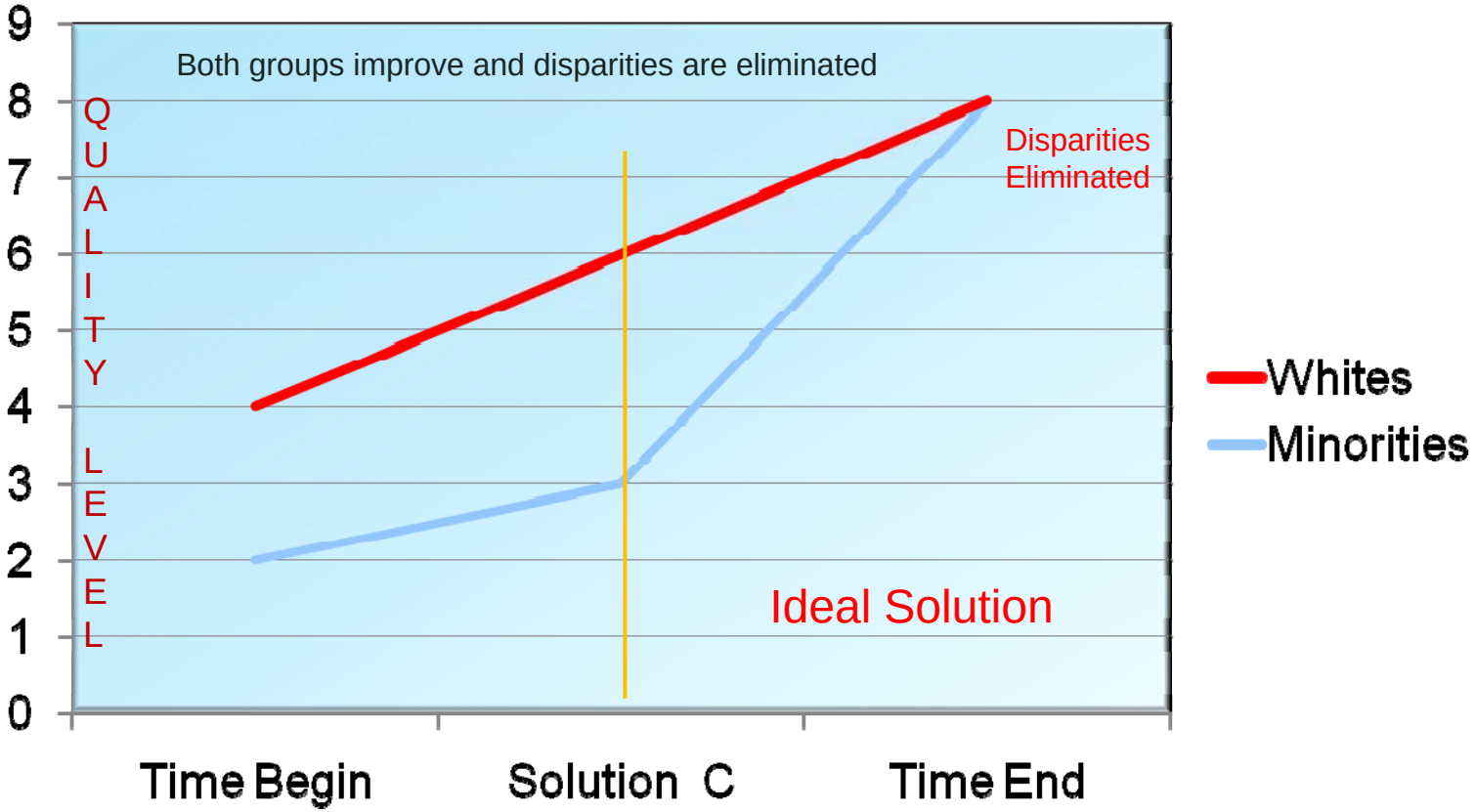


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# Health Disparities Math

- Assume quality gradient of 1 → 10 (best):

Whites = 6 and minorities = 4

Disparity difference = 2

- Goal: Improve quality to 9:

We need to achieve a 50% (6 to 9) increase for whites and 125% (4 to 9) increase for minorities in order to achieve equity.

- If we achieved a 50% equal improvement for all:

Whites = 6 to 9 minorities = 4 to 6

Disparity difference = 3

- Therefore we have a worsening quality disparity of 50%.

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# MCIPA Quality Improvement Strategy


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# Questions ?

- Does your group or institution collect demographic racial and ethnic data?
- Has your group or institution developed a strategy to monitor and address health disparities?
- Should we develop QI measures that adjust for race and ethnic differences?

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